

CHAPTER IV  
COVERED SERVICES AND LIMITATIONS

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## CHAPTER IV COVERED SERVICES AND LIMITATIONS

### DEFINITION OF CASE MANAGEMENT SERVICES

Case management services are an integral component of the overall service delivery system for individuals with AIDS/ARC. Virginia offers case management services as a waiver service to enable the continuous assessment, coordination, and monitoring of the needs of the persons diagnosed with AIDS or ARC throughout the term of the individual's receipt of waiver services. Case management services are viewed as an **indirect service** necessary to the successful avoidance of institutional care for individuals with AIDS. Case management enables the efficient and effective delivery of the other, **direct services** which are viewed as the services responsible for the delay or avoidance of institutionalization: personal care, private duty nursing, nutritional supplements, and respite care.

Every AIDS/ARC individual authorized for waiver services must be offered case management services as an adjunct to these other direct waiver services. A Medicaid-eligible individual may not be authorized for waiver services unless that individual is both diagnosed with AIDS or ARC **and** is experiencing symptoms which require the delivery of a home and community-based service other than case management. Case management services must be offered to all individuals authorized for waiver services to ensure the continued appropriateness for waiver services and that the services rendered are adequate in quality, scope, and amount to promote the individual's safety and welfare in the community. The case manager is the individual designated by the case management provider as responsible for conducting the re-evaluation and review of the individual's plan of care.

For an individual with AIDS or ARC to be authorized to receive AIDS waiver services, the individual must be in need of a direct service (personal care, private duty nursing, respite care) in addition to case management services. However, once AIDS waiver services have been initiated, direct services may be terminated while maintaining the case management services and the individual's status as an AIDS waiver recipient. Due to the episodic nature of the AIDS disease, it is expected that persons with AIDS or ARC will fluctuate in their utilization of direct waiver services as their symptoms abate. They should, however, continue to receive case management services as long as the continuous receipt of case management can be shown to prevent the individual's institutionalization.

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Case management services will be reimbursed only for those contacts made **directly** by the case manager, not by any individuals supervised by the case manager having interaction with the AIDS waiver recipient. The minimal degree of contact required by DMAS must be provided each month by the case manager.

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The case manager may provide any assessment, coordination, monitoring, or referral services necessary as a part of managing the recipient's care in the community. This activity must be documented in the monthly log maintained by the agency and must upon review by DMAS staff be deemed necessary and consistent with high quality care assurance.

The case management agency will be reimbursed according to an hourly fee scale of \$15 per hour (\$20 per hour in Northern Virginia) up to a maximum amount of 10 hours of case management rendered in any month. This rate of reimbursement has been established to reflect the personnel costs for staff required by DMAS standards with an appropriate amount of administrative cost included. An hourly rate was chosen due to the degree of variance among the needs of this population.

Typical case management activities which are reimbursable by DMAS include, but are not limited to:

- An initial assessment visit with the recipient in the recipient's residence;
- Contacts with the direct AIDS service providers for the purposes of referral for service, monitoring of current service delivery, problem solving/technical assistance, changes to the plan of care, etc.;
- Contacts with the recipient, friends, family, physician, and other professionals involved in the recipient's care for the purposes of assessment, coordination, and monitoring;
- Occasional revisions to the plan of care (the case manager is responsible for all changes made to the recipient's network of AIDS services and thus must revise the plan of care whenever any service is modified); and
- Quarterly re-evaluations conducted with the recipient and case management team during which the DMAS-95, and plan of care if necessary, are updated. (See Appendix B for a sample of this form.)

#### **MEDICAID-FUNDED AIDS/ARC DIRECT HOME AND COMMUNITY-BASED CARE SERVICES**

The Department of Medical Assistance Services provides reimbursement for a variety of in-home services to individuals who meet the criteria for AIDS/ARC waiver services (personal care, private duty nursing, respite care, and nutritional supplements not covered under the State Plan and deemed medically necessary as the primary source of the recipient's nutritional needs). These services are designed to offer individuals an alternative to institutionalization. Individuals may

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be authorized to receive one or more of these services either solely or in combination, based on the documented need of the service(s) to avoid hospital or nursing home placement. The nursing home pre-admission screening committee must give prior authorization for any Medicaid-reimbursed home and community-based care, subject to DMAS approval prior to the implementation of any services.

### **Personal Care Services**

Personal care services are defined as long-term maintenance or supportive services which are necessary to enable the individual to remain at home rather than enter a nursing facility. Personal care services may be offered to individuals only through an agency with which the Department of Medical Assistance Services has contracted to provide personal care. Personal care is rendered by personal care aides who receive continuous, ongoing supervision from registered nurses which includes a supervisory visit in the recipient's home at least every 30 days. Although personal care aides may provide care to individuals meeting skilled-level criteria, they cannot perform any services not identified in this section.

A. The services provided by personal care aides are limited to:

1. Assisting with care of the teeth and mouth
2. Assisting with grooming (this would include the care of hair, shaving, and the ordinary care of nails)
3. Assisting with the bathing of the individual in the bed, in the tub, or in the shower. Routine maintenance and care of external condom catheters is considered part of the bathing process and can be provided by the personal care aide. This care applies only to external condom catheter care and not indwelling catheters, i.e., Foleys, which require sterile procedures and the professional skills of a registered nurse.
4. Providing routine skin care, such as applying lotion to dry skin; it does not include the application of topical medications.
5. Assisting the individual with dressing and undressing
6. Assisting the individual to turn and change position, transfer, and ambulate
7. Assisting the individual to move on and off of the bedpan, commode, or toilet

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8. Assisting the individual with eating or feeding
9. Assisting the individual with self-administered medications and assuring that the individual receives medications at prescribed times, but it does not include pouring or, in any way, determining the dosage of the medication.
10. Checking the temperature, pulse, respirations, and blood pressure and recording and reporting as required
11. Preparing and serving meals, but it does not include menu planning for special diets.
12. Washing the dishes and cleaning the kitchen
13. Making the bed and changing the linens
14. Cleaning the individual's room(s) and bath area
15. Listing for purchase the supplies needed by the individual
16. Shopping for the necessary supplies for the individual
17. Washing the individual's laundry
18. Supervision - The nursing home pre-admission screening committee could include supervision on an individual's plan of care once a determination has been made that the individual must have 24-hour supervision to be safely maintained at home and that the individual's support system is inadequate to provide the total 24-hour care the individual needs. The inclusion of supervision to the plan of care for a recipient is appropriate when the recipient cannot be left alone at any time due to mental or severe physical incapacitation and when there are no other resources available to provide the needed supervision. Individuals who cannot be left alone are typically those who are either confused and therefore likely to wander or be a danger to themselves if unsupervised or those who are bed-confined and either cannot call for assistance or do not have nearby support to assist in the event of an emergency. Supervision cannot be considered necessary because the recipient's family or provider is concerned about leaving the recipient alone for long periods of time or would prefer to have someone with the recipient. There must be a clear and present danger to the recipient as a result of being left unsupervised.

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The nursing home pre-admission screening committee must document in the plan of care the justification for the need for supervision and the identity of all other support persons and their ability to provide supervision. For these clients, there must be a plan for their supervision which involves the physical presence of another person in the home on a 24-hour basis. Although there is no maximum amount of time that an aide can provide care to a recipient, the family or support system must be able to provide a significant amount of time to the recipient in order for personal care to be a viable option for those whose needs require 24-hour supervision.

Supervision may not be the only task authorized on the individual's plan of care but must only be included as a supplementary task to other personal care tasks being performed for an individual.

19. Administration of physician-ordered bowel and bladder programs by the personal care aide under special training and supervision - The personal care aide may be authorized to administer bowel and bladder programs to individuals who do not have any other support available. This authorization could only be given if written signed orders by a physician are obtained and the provider agency has documented that the aide has received special training in bowel and bladder program management, has a knowledge of the circumstances that require immediate reporting to the nurse supervisor, and the nurse supervisor has observed the aide performing this function. The nurse supervisor must be available to the aide and able to respond to any complications immediately. The physician's written order must specify the method and type of digital stimulation and frequency of administration. The screening committee may not include this service on the plan of care prior to contacting the agency chosen to provide the service to assure an aide with adequate training is available.

Certain conditions exist that would contraindicate having the aide perform a bowel program, i.e., patients prone to dysreflexia such as high level quadraplegics, head and spinal cord injured patients, and some stroke patients. The bowel program administered by the aide may include, if ordered by the physician, an enema or suppository to stimulate defecation. However, a laxative can not be "administered" by the personal care aide, even though a part of the bowel program. Replacement of a colostomy bag as part of the bath is included. Digital stimulation and removal of feces within the rectal vault may be a necessary part of the bowel maintenance or training program. However, removal of impacted material is not permitted.

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The bladder program may not include any invasive procedures such as catheterization, instillations or irrigations, but can include bladder retraining activities. Bladder retraining is limited to the time management of urination without any invasive procedures or voiding stimulation.

20. Administration of maintenance range of motion exercises by the personal care aide when ordered by the physician - Range of motion exercises may be performed by the aide when the aide has been instructed by the nurse supervisor in the administration of maintenance range of motion exercises and when the aide's performance of these exercises has been witnessed and documented by the nurse supervisor. The nurse supervisor must document in the recipient record the continued need for range of motion exercises and the monitoring of the aide's performance of these exercises in the 30-day nursing note. This does not include strengthening exercises or exercises aimed at retraining muscle groups, but includes only those exercises used to maintain current range of movement without encountering resistance.
  21. Routine wound care not requiring sterile treatment or sterile dressings by the personal care aide - This would include the care of a routine decubitus which is superficial or does not exceed Stage II (the sore penetrates to the underlying subcutaneous fat layer, shows redness, edema and induration at times with epidermal blistering or desquamation). Routine wound care would include flushing with normal saline solution, washing the area, drying the area, and applying dry dressings as instructed by the nurse supervisor. This does not include the application of any creams, ointments, sprays, powders or occlusive dressings.
- B. The Department of Medical Assistance Services will not reimburse personal care agencies for the personal care aide providing skilled services or any other services not outlined as personal care services in this section. DMAS also absolves itself of any responsibility for the provision of unauthorized services. These services are:
1. A personal care aide is not allowed to transport (i.e., drive a vehicle for) an individual. The family and/or social support is expected to perform this service or make arrangements for alternate transportation (taxi, ambulance, etc.).

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2. Personal care aides cannot perform services requiring professional skills, such as tube feedings, Foley catheter irrigations, sterile dressings, or any other procedure requiring sterile techniques. It is permissible for a skilled nurse to give services at the same time that a personal care aide is in attendance.
3. Pre-admission screening committees must also be aware that a personal care aide cannot perform diabetic urine testing, heavy cleaning, reality orientation as a separate service, or socialization as a separate service.
4. DMAS will reimburse the provider agency only for personal care services rendered to the individual. DMAS will not reimburse the provider agency for services rendered to or for the convenience of other members of the individual's household. DMAS also will not reimburse for the provision of unauthorized personal care services.

### Respite Care

Respite care is defined as services specifically designed to provide a temporary but periodic or routine relief to the primary caregiver of an individual who is incapacitated or dependent due to frailty or physical disability. This definition embodies the following key concepts:

- A primary caregiver who lives in the home and who requires temporary relief from the stress of continual caregiving;
- An incapacitated or dependent individual who requires continuous and long-term care due to advanced age or physical disability;
- In-home services which are designed to relieve the physical and emotional burdens of the caregiver and only secondarily the needs of the care-receiver; and
- The prevention of individual and/or family breakdown and the consequent institutionalization which may result from the physical burden and emotional stress of providing continuous support and care to a dependent individual.

This definition distinguishes between respite care and the other services in the continuum of long-term care. The four concepts listed above focus on the need of the caregiver for temporary relief. This focus on the caregiver differentiates respite care from programs which focus on the dependent or disabled care-receiver.

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Respite care services may be authorized by the screening committee when it is determined that respite care is the critical alternative to nursing home care. Respite care can be authorized as either an **episodic**, temporary relief of the caregiver for a short-term period of time or as a **routine**, periodic relief of the caregiver over an extended period. An example of respite care authorized as an **episodic**, temporary relief is the authorization of a week's period (7 days, 24 hours a day) of respite care while the caregiver takes a vacation. An example of respite care as **routine**, periodic relief is the authorization of one day a week of respite care to allow the caregiver a routine break from continuous care. The type of authorization will depend upon the individual circumstances of the caregiver and care-receiver. In all instances where authorization of respite care is given, clear documentation of the need for the amount and type of respite care authorized must be provided.

The authorization of respite care is limited to 30 (24-hour) days over a 12-month period. Reimbursement is made on an hourly basis for any amount authorized up to eight hours. Any amount over an eight-hour day will be reimbursed on a per diem basis.

When an individual receives personal care and wishes to also receive respite care as an episodic relief due to a caregiver's illness, etc., the DMAS Community-Based Care Section analyst assigned to the provider's locality must be contacted. **The screening committee may not authorize respite care in conjunction with personal care.** DMAS will assess the need for episodic respite care in coordination with personal care. Respite care as a routine, periodic relief may not be offered in conjunction with personal care.

Respite care services may be provided by a respite care aide, a licensed practical nurse (LPN), or a registered nurse (RN) depending upon the needs of the individual and the support system available. A provider must have either a respite care contract (for aide or LPN care) or a private duty nursing contract (for LPN or RN care) with DMAS to be qualified to render services through this waiver. Respite care services can only be offered by an LPN or RN if the individual requires a skilled level of care on a continuous basis and if there is no one available to provide skilled services in the absence of the primary caregiver. For example, an individual who requires a skilled level of care for wound irrigation and sterile dressing change does not require an LPN or RN to provide respite care services as long as a home health nurse could perform the wound care (or perhaps a friend or family member could be trained to provide this care). However, the individual who has a tracheostomy and requires skilled observation and care would be an appropriate individual for LPN or RN respite care. In all cases, the level of skilled professional care should not exceed the needs of the individual.

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Respite care services may include the following activities performed by a respite care aide:

- Assistance with ambulation;
- Bathing;
- Dressing;
- Assistance with turning and changing positions;
- Meal and snack preparation;
- Assistance with eating;
- Supervision of medications **(The Respite Care aide must not administer medications.)**;
- Vital signs;
- Assistance with toileting;
- Assistance with transferring (example -- from bed to wheelchair);
- Light housecleaning;
- Assistance with grooming and personal care;
- General supervision;
- Accompaniment on trips away from home, i.e., grocery store, doctor's office, etc.;
- Socialization;
- Shopping;
- Laundry; and
- Special maintenance activities such as routine care of the superficial decubitus, routine care of an external condom catheter, physician ordered bowel and bladder programs, and simple range of motion exercises.

In addition, the LPN can perform selected nursing procedures performed under the direction of an RN. Such selected procedures may include:

- Administration of medications
- Care of tracheostomies, feeding tubes, etc.
- Wound care requiring aseptic technique

A registered nurse should only be utilized to provide respite care when the individual's needs require continuous skilled observation and an LPN is either not appropriate or not available.

Respite care services may be offered to individuals only through an agency with which DMAS has contracted to provide respite care. A registered nurse will provide ongoing supervision to include a supervisory home visit every 30 days when respite care is authorized as a routine service. For episodic respite care, the RN supervisor must make an initial supervisory visit and a concluding supervisory visit. The RN supervisor must always be available by phone to the aide or LPN at any time they are providing respite care services.

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### **Private Duty Nursing Services**

Private duty nursing is professional nursing care provided by a registered nurse or licensed practical nurse in the individual's home or other community setting. This nursing service may be authorized if it is necessary to avoid institutionalization of the individual with AIDS by assessment and monitoring of the medical condition, rendering direct care, and communicating with the physician regarding changes in the patient's status. DMAS will contract with agencies that meet the standards and requirements set forth by DMAS, agree to render services according to the policies and procedures established as requirements for private duty nursing, and have a current, signed contract with DMAS. Skilled nursing may be authorized in any amount which is appropriate to meet the needs of the patient and is overall cost-effective.

### **Nutritional Supplements**

DMAS will reimburse for physician-ordered nutritional supplements when the individual requires the nutritional supplement as the primary source of nutrition and is not able to purchase these food supplements through other available means (Women, Infants and Children food program; Medicare; or foodstamps). Nutritional supplements are not covered as a part of the State Plan unless they are parenteral supplements containing a legend drug. Nutritional supplements which do not contain a legend drug are only available through Virginia's Women, Infants and Children (WIC) program which provides vouchers for the purchase of nutritional supplements for children under the age of six or those which can be purchased with foodstamps by those individuals whose income falls within the limits established by this federal food program. Due to the prevalence of conditions of wasting, malnutrition and dehydration, many individuals with AIDS or ARC require nutritional supplements as a component of their health care plan.

Nutritional supplements must be pre-authorized by the individual's case manager. The amount of supplements which may be authorized should be appropriate to the needs and circumstances of the individual with AIDS/ARC, but may not exceed a three-month supply. DMAS will issue written notification of the authorization to the waiver recipient. The recipient must present the written notification to the pharmacy of his or her choice to purchase the supplements. The pharmacy will bill Medicaid using the pre-authorization number included on that form. Payment will be denied for any claim submitted without a pre-authorization active for the month in which the supplements are being purchased.

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## **RELATION TO OTHER HOME AND COMMUNITY--BASED CARE SERVICES**

Virginia offers Medicaid reimbursement for home and community-based care services through several separate waivers granted by the Health Care Financing Administration (HCFA) in accordance with Section 1915(c) of the Social Security Act. Section 1915(c) allows HCFA to waive certain statutory requirements in order to allow states to offer those home and community-based care services which prevent institutionalization of Medicaid-eligible individuals. Continued federal approval for waiver programs is contingent upon the state's ability to document that the population targeted to receive waiver services was, in fact, a population that would otherwise have required institutional care and that the cost of home and community-based care services is equal to or less than the cost of such institutional care. Individuals must be pre-authorized to receive services through one of the approved waivers; there can be no overlap between the different waivers.

In addition to the AIDS/ARC waiver, Virginia offers services through three other waivers:

1. An elderly and disabled waiver which includes personal care, respite care, and adult day health care services offered to elderly and disabled individuals who would otherwise require nursing facility level of care
2. A waiver for technology-assisted individuals under the age of 21 which includes skilled nursing, respite care, and nutritional supplements deemed necessary by a physician as the individual's primary source of nutrition, offered to individuals who would otherwise require the hospital level of care
3. A waiver for individuals with mental retardation which includes residential support, day treatment, habilitation, case management, and therapeutic counseling services offered to individuals who would otherwise require the level of care provided in a nursing facility for the mentally retarded

Virginia currently offers two other home-based services through the State Plan: home health and hospice care. Home health is a community-based service covered under the Virginia State Plan, rather than as a waiver service, such as personal care. The major differences between home health and personal care services are the increased involvement of professional medical personnel in home health services and the emphasis in home health on restorative rather than long-term maintenance functions. A home health aide shall be assigned when the responsible physician has specified the need for such a service in the recipient's plan of treatment. This plan of treatment must be re-evaluated and signed by the responsible physician not less

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than once every sixty (60) days. The registered nurse shall make a supervisory visit to the recipient's residence at least every two (2) weeks to assess relationships and determine whether the goals are being met.

Personal care aides cannot perform services requiring professional skills, such as tube feedings, Foley catheter irrigations, sterile dressings, or any other procedures requiring sterile technique. It is permissible for a home health nurse to give skilled services at the same time that a personal care aide is in attendance. Medicaid cannot be billed for a home health aide and a personal care aide providing identical services to the same recipient at the same time.

Hospice is an autonomous, centrally-administered, medically-directed program providing a continuum of home, outpatient, and homelike inpatient care for the terminally ill patient and his or her family. It employs an interdisciplinary team to assist in providing palliative care to meet the special needs arising out of the physical, emotional, spiritual, social, and economic stresses which are experienced during the final stages of illness and during bereavement. The goal is to maintain the individual at home for as long as possible while providing the best care available to the patient, thereby avoiding institutionalization. To be covered, hospice services must be reasonable and necessary for the palliation or management of the terminal illness as well as related conditions. If the individual certified as being terminally ill elects hospice coverage, the individual waives the right to any other Medicaid services for the terminal illness. A hospice must routinely provide a core set of services which include nursing care, physician services, social work, and counseling. Hospice care should be considered as an alternative for the individual with AIDS being screened for AIDS waiver services.

#### **ASSESSMENT AND AUTHORIZATION PROCEDURES FOR AIDS/ARC WAIVER SERVICES**

AIDS/ARC waiver services will be offered only to individuals who have been certified eligible for nursing facility level of care or hospital level of care for a condition of AIDS/ARC by a nursing home pre-admission screening committee (NHPASC) or the Department of Medical Assistance Services utilization review analyst. The committee will have explored the medical, social, and nursing needs of the individual; analyzed the specific services needed by the individual; and evaluated whether a service or combination of existing services is available to meet these needs. The committee will have explored alternative settings and/or services to provide the required care before making the referral for AIDS/ARC waiver services. A copy of the DMAS criteria for nursing facility and hospital level of care is located in Appendix C.

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Federal regulations governing the Medicaid coverage of home and community-based services under an approved waiver specify that services provided under waiver authority must be targeted to individuals who **otherwise** would have to be institutionalized and the home and community-based care services provided must cost less than or be equal to the cost of institutional care for the same population. Under the waiver for individuals with AIDS or ARC, community-based care services may be furnished only to persons:

1. Who require the level of care provided in a hospital or nursing facility.
2. Who have been diagnosed by a physician who is part of the designated pre-admission screening committee as having AIDS or ARC and who are experiencing medical and functional symptoms associated with AIDS or ARC.
3. Who are not residents of hospitals, nursing care facilities, homes for adults, or adult foster homes licensed by the Department of Social Services.
4. For whom an appropriate plan of care can be developed which is expected to cost equal to or less than institutional services and which will ensure the individual's safety and welfare in the home and community.
5. Who are financially eligible for Medicaid.
6. Where there are no other, or insufficient, community resources available to meet the recipient's needs.

To ensure that Virginia's AIDS/ARC waiver program services are provided **only** to individuals who would otherwise be placed in a nursing facility, AIDS/ARC waiver services **can be considered only for individuals who are seeking or are at imminent risk of hospital or nursing home admission**. AIDS/ARC waiver services must be the critical service that enables the individual to remain at home rather than being placed in an institution.

The recipient's status as a recipient in need of AIDS/ARC waiver services is determined by the nursing home pre-admission screening committee. A request for a pre-admission screening for nursing home placement can be initiated by the individual who desires the requested care, a family member, a physician, a local health department or social service professional, or any other concerned individual in the community. The Long-Term Care Assessment Instrument must be completed in its entirety. The Nursing Home Pre-Admission Screening Authorization (DMAS-96) and the Medicaid HIV Services Plan of Care (DMAS-113B) must also be completed by the committee and approved by the public health physician or attending physician, whichever is appropriate. (See Appendix B for samples of these forms.) The plan of care indicates the services needed, any special needs of the

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recipient and environment, and the support available to provide services. The screening committee will note the number of days per week that care is needed but will not authorize the amount of service each day. The screening team plan of care will also document the recipient's choice of long-term care options and the choice of provider. **If AIDS/ARC waiver services are authorized and there is more than one approved provider agency in the community willing and able to provide care, the individual must have the option of selecting the provider agency of his or her choice.**

The pre-admission screening committee recommends the authorization for AIDS/ARC waiver services for the AIDS/ARC individual to DMAS which makes the final authorization prior to service initiation. DMAS will complete an authorization form which notes the cost-effectiveness of waiver services and the date upon which waiver services are authorized. This form must be attached to the screening package which is sent to the AIDS/ARC service provider to initiate services.

Screening and preauthorization of AIDS/ARC waiver services by DMAS is mandatory before DMAS will assume payment responsibility for AIDS/ARC waiver services. DMAS will assume the payment responsibility for AIDS/ARC waiver services only after the Department of Social Services has determined that the individual is financially eligible for medical assistance for the dates on which the services are to be provided.

## **FORMS REQUIRED FOR ADMISSION TO AIDS/ARC WAIVER SERVICES**

The screening committee which is initiating a referral will send the case management provider an admission package consisting of the original of the Long-Term Care Assessment Instrument (DMAS-95), the MI/MR Supplement (DMAS-95 MI/MR), the original and a copy of the Nursing Home Pre-Admission Screening Authorization (DMAS-96), and DMAS authorization form, and the original and a copy of the Medicaid HIV Services Plan of Care (DMAS-113B). These forms will be thoroughly completed by the screening committees and forwarded to the case management provider. Screening committees will make AIDS/ARC waiver referrals only to agencies which have met Medicaid requirements and are enrolled under contract as a Medicaid AIDS/ARC waiver provider agency. (Appendix B contains samples of these forms.)

## **CASE MANAGEMENT AGENCY RESPONSE TO REFERRAL**

The provider agency shall not begin services for which they expect Medicaid reimbursement until the admission package (DMAS-95, DMAS-95 MI/MR, DMAS-96, and DMAS-113B Plan of Care) is received from the pre-admission screening team and before the date authorized by DMAS as stated on the DMAS-96 or DMAS authorization form. (See Appendix B for samples of these forms.)

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Upon the receipt of a referral, the case management provider will contact all other direct service providers which have been authorized to render AIDS/ARC waiver services to the recipient to confirm that they have received a copy of the pre-admission screening package (pre-admission screening committees are instructed to send the original documentation to the case manager and a copy to each of the other services authorized) and are preparing to initiate services. Any difficulties with the prompt initiation of service should be addressed at this time with the case manager serving as facilitator and reviewer of the plan of care developed by the screening committee.

The case manager will create a recipient file and begin documentation on a monthly log by recording the first contacts to direct service providers to monitor service implementation (see Chapter II, page 9, for the contents of the recipient file and the data required for inclusion in the monthly log). The case manager must record a summary of the first 30 days of service delivery to the recipient on a recipient progress report. Every 30 days thereafter, the case manager must record a summary of the recipient's status and the status of his or her service delivery system in the recipient progress report (see Chapter II, page 9, for the contents of the recipient progress report). The monthly log and recipient progress report are not DMAS forms. However, the case management provider must record in a format which allows review by State and federal review staff and which includes all of the information required as stated in Chapter II, page 9.

Each of the direct service provider agencies must submit to the case manager a copy of its individualized waiver service plan (e.g., personal care agencies develop a personal care plan of care, the DMAS 97-A, which details the specific tasks to be performed by the personal care aide). The case manager must review these plans of care for appropriateness and adequacy and maintain them in the case manager's recipient file.

If the case manager determines that the provider plan of care developed by the direct service provider does not appropriately meet the needs of the recipient, the case manager must communicate this in writing to the direct service provider and indicate the action which must be taken to correct the plan of care. A copy of this communication must be sent to the DMAS analyst responsible for utilization review for AIDS waiver recipients.

The case manager is authorized by DMAS to make decisions related to recipient quality of care issues and his or her decisions regarding an AIDS individual's receipt of waiver services cannot be appealed by the direct service provider. Any concerns the direct service provider has regarding a case manager's decision should be expressed to the case manager in writing, and a copy may be sent to DMAS.

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It is the case manager's responsibility to act as the approval source for any change required to a DMAS authorized service. For example, if DMAS has authorized five hours per week of private duty nursing and 30 hours per week of personal care for an AIDS waiver recipient, the providers of private duty nursing and personal care must contact the case manager for any change in the amount or type of care rendered (personal care agencies are allowed to make some changes without prior approval and would make those changes pursuant to the Personal Care Services Manual).

It is DMAS' responsibility to authorize any new service in the individual's plan of care. For example, if DMAS has initially authorized 20 hours per week of personal care for an AIDS waiver recipient and the recipient's condition worsens requiring an increase in personal care and the authorization of private duty nursing, the case manager can authorize the increase in the personal care hours but must obtain DMAS approval for the implementation of the new service, private duty nursing.

#### **CASE MANAGEMENT PROVIDER'S RESPONSIBILITY FOR THE PATIENT INFORMATION FORM (DMAS-122)**

The Patient Pay Information form (DMAS-122) is used by the case management provider and the local Department of Social Services to exchange information regarding the eligibility status of a Medicaid-eligible recipient. (Appendix B contains a sample of the form and the instructions for its completion.) The provider is responsible for ensuring that a current completed DMAS-122 is in the recipient's record. A new DMAS-122 is required at least annually. Uses of the DMAS-122 include:

##### **AIDS/ARC Waiver Service Initiation**

As soon as the case management agency initiates services, it must send a Patient Information form (DMAS-122) to the eligibility unit of the appropriate local Department of Social Services indicating the effective date AIDS/ARC waiver services began. The case manager, as a function of the overall coordination of waiver services, will note the effective begin dates for each of the services authorized. Direct service providers will not be required to initiate a separate DMAS-122.

It is advisable for the provider agency to contact the eligibility worker prior to the start of AIDS/ARC waiver services for assurance of the recipient's Medicaid eligibility. After being notified of the begin date of service, the eligibility worker will return the same DMAS-122 to the provider agency with the bottom section completed, showing confirmation of the recipient's Medicaid identification number, the recipient's income, and the date on which the recipient's Medicaid eligibility was effective. The case manager must send a copy of the returned DMAS-122 to the direct service providers.

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### Patient Pay Amount

Each Medicaid recipient of home and community-based care is allowed to keep a portion of his or her income to meet his or her own maintenance needs. This maintenance allowance is higher for the individual staying at home in community-based care than for the individual in a nursing facility. The maintenance allowance for an AIDS/ARC waiver services recipient is equal to 300% of the current Supplemental Security Income (SSI) individual payment standard. The maintenance allowance and any other allowable deduction (e.g., medical insurance payments) are deducted from the individual's income to arrive at that individual's patient pay amount.

### Additional Uses of the DMAS-122

It is the responsibility of the provider agency to notify DMAS, in writing, and the Department of Social Services via the DMAS-122 when any of the following circumstances occur:

- A recipient dies (including the date of death)
- A recipient is discharged or terminated from services (including the date of discharge or termination. This date must be the date of the last service rendered for the recipient.)
- Any other circumstances (including hospitalization) which cause AIDS/ARC waiver services to cease or become interrupted for more than thirty (30) days

### **CASE MANAGEMENT AGENCY MONITORING OF RECIPIENT SERVICES**

The case management agency is responsible for monitoring the ongoing provision of services to each Medicaid AIDS/ARC waiver recipient. This monitoring includes:

- The quality of care provided by the direct service providers rendering care;
- The functional and medical needs of the individual and any modification necessary to DMAS authorized services included in the recipient's plan of care due to a change in these needs; and
- The individual's need for support in addition to care provided by Medicaid-funded services. This includes an overall assessment of the individual's safety and welfare in the home with AIDS/ARC waiver services.

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The case management provider agency is responsible for taking the appropriate action to assure continued appropriate and adequate service to AIDS/ARC waiver recipients. Appropriate actions may include: discussion with the direct service provider agency regarding the care to be provided to the recipient, requesting an additional service from DMAS to include in the recipient's plan of care, and discussing with the recipient's family the need for additional care for the recipient or contacting DMAS to request a special review of the recipient's case. Anytime the case manager is unsure of the action which needs to be taken, the case manager should contact the DMAS utilization review staff assigned to the agency for consultation.

### Health and Safety Issues

When the case management agency becomes aware that AIDS/ARC waiver services and the recipient's current support system may not adequately provide for the recipient's safety, the agency should immediately request the DMAS utilization review analyst to make a special home visit review. DMAS will schedule a meeting with the recipient, the recipient's family, other social support, other appropriate social service agency representatives, and the provider nurse and aide. The intent of this meeting will be to determine whether the recipient's current status represents a potential risk or an actual threat to his safety, health, and welfare.

A potential risk is identified as a deterioration in either the recipient's condition and/or environment which, in the absence of additional support, could result in harm or injury to the recipient. An actual threat is the presence of harm or injury to the recipient which can be attributed to the recipient's deterioration and lack of adequate support (i.e., the recipient becomes anemic, malnourished, dehydrated due to the inability to obtain food and water; the recipient develops decubitus due to lying in urine or feces, etc.).

To determine whether an actual threat may exist, the agency should consider the following:

1. Is the recipient capable of calling for help when needed?
2. Is there a support system available for the recipient to call?
3. Can conditions be arranged for the recipient to care for basic needs when the support system is absent?
4. Is the recipient medically at risk when left alone (i.e., is the recipient falling frequently)?
5. Has some harm or injury to the recipient been reported?
6. Does the recipient express fear or concern for his or her welfare?

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If answers to the above indicate a potential risk, the agency should still advise the utilization review analyst of the situation, and the analyst can determine if a special home visit is indicated.

When a real threat to the recipient's health, safety and welfare exists, the analyst will attempt to assess whether additional services can be obtained to maintain the recipient in a home environment. If continued maintenance in the home is not possible, the analyst will initiate procedures to terminate services and will advise the local Department of Social Services social worker that institutional services should be considered. The provider agency should not attempt to terminate a recipient's services due to safety and welfare concerns because an agency's action does not allow the recipient the right to appeal which the action by DMAS staff allows.

#### Changes to the Plan of Care

The case manager is responsible for making modifications to the plan of care as needed to assure that services are appropriate to meet the current needs of the recipient. The case manager is able to authorize changes to the amount or type of service previously authorized by DMAS in the individual's HIV service plan of care which are appropriate to meet the recipient's needs. Any request for a service which has not been authorized by DMAS as part of the AIDS waiver recipient's approved plan of care must be made by the case manager to the DMAS analyst responsible for AIDS waiver recipient utilization review (see page 15 of this Chapter).

Anytime the number of hours of direct service for a recipient need to be changed, a new provider agency plan of care must be developed by the direct service provider and a copy sent to the case manager. The most recent plan of care must always be in the recipient's home. The direct service provider will follow the instructions in the provider service manual regarding the conditions under which he or she must receive prior approval to change the amount, duration, or scope of direct services to recipients. Anytime the direct service provider's DMAS manual indicates prior authorization must be received, the direct service provider will be instructed to receive this authorization from the case management provider. The request, decision, and authorization for, or denial of, a change in the amount, frequency, or tasks performed by the authorized direct service providers can be transmitted by telephone, and the case manager must note this decision in the recipient's record.

The case manager must send a letter to the recipient confirming approval of the change in service and providing the recipient the right to appeal the decision. The case manager must send a copy of this letter to DMAS and the direct service provider. If the case manager does not approve the request to change the amount of care (whether the change is requested by the recipient or on the recipient's behalf by the direct service provider), the letter to the recipient must indicate the reason the change was not made. This letter must also give the recipient notification of his or her right to appeal this decision. The case manager must send a copy of this letter to the provider agency and to DMAS.

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## RIGHT OF APPEAL

The case manager, by letter, must inform the individual of any decision to revise or terminate the authorization for AIDS/ARC waiver services and must indicate the reason(s) for the decision. Any individual wishing to appeal should notify the Division of Client Appeals, Department of Medical Assistance Services, in writing, of his or her desire to appeal within thirty days (30) of the receipt of the committee's decision letter. The following statement must be included in every decision letter (revision or denial):

"You may appeal this decision by notifying, in writing, the Client Appeals Division, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, Virginia 23219. This written request for an appeal must be filed within thirty (30) days of this notification. If you file an appeal before the effective date of this action, (date), services may continue during the appeal process. However, if this decision is upheld by the Client Appeals Division, you will be required to reimburse the Medical Assistance Program for the personal care services provided after (date)."

When a request for an appeal is received a letter is sent to the recipient and a copy to DMAS validating the appeal and scheduling a hearing.

If the recipient files an appeal before the effective date of the action, the hearing officer notifies the recipient in writing that his or her services can continue unchanged during the appeal, and that the recipient should contact the Client Appeals Division if he or she does not wish services to continue. The Client Appeals Division sends a copy of this letter to the provider, the case manager, and the utilization review analyst assigned to the case to inform all parties of the continuation of services. Upon the receipt of this letter, the case manager should contact the provider to assure the appropriate delivery of services and should document in the appeal summary if the recipient chooses to continue services.

The utilization review analyst will review with the case manager and provider RN (or the recipient) the circumstances that created the adverse action to determine if there has been any change which might invalidate the adverse action decision. For example, if an action to decrease the hours due to the decreased needs of the recipient has been appealed, the analyst should discuss with the agency RN or recipient whether the recipient's needs have become greater or social support has decreased since the action was taken.

If it appears that there has been a change, the case manager may reconsider the action taken. If, after the reassessment, the case manager decides to withdraw the initial decision, the case manager should advise the recipient in writing that the

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initial action has been withdrawn, the specific reasons for this decision, and that services will continue at the previous level. A copy of this letter should be sent to the appeals hearing officer who will then send the recipient a letter inviting him or her to withdraw the appeal.

If the reassessment does not indicate a change which would invalidate the initial decision, the case manager should document this in the appeal summary. If the summary has already been submitted, the case manager should send a letter to the recipient which details the outcome of this re-assessment and states that the initial decision continues to be valid. A copy of this letter should be sent to the appeals hearing officer. When the case manager receives notice that an appeal has been validated, there will be 10 days to prepare and submit an appeals summary. The case manager must send a copy of the appeals summary package (the appeals summary and all attachments) to all parties who have been notified of the hearing, including an attorney or other legal representative.

**The appeal summary must be written with the assumption that the individuals who will read it have no knowledge of the individual's circumstances or of the waiver policies. It should summarize the individual's status at the time the action was taken, what action was taken, and the reason for the action.**

A hearing will be held at the site scheduled by the hearing officer. During the hearing, the hearing officer will ask the case manager to summarize the Department's actions. The case manager should give a brief summary of the action taken and the reasons for the action. During this summary, the case manager can introduce any information omitted from the appeal summary. The hearing officer will then ask the recipient to respond, giving the reasons he or she thinks the action should be reversed. It is the case manager's role during the hearing to take notes, clarify points of discussion, and ask questions to assure the Department's actions are clearly understood.

Following the appeal hearing, the hearing officer renders a written decision to sustain or overturn the action taken by the case manager. The case manager will be informed of the hearing officer's decision. If the recipient does not agree with the hearing officer's decision, the recipient can appeal the hearing officer's decision to the Medical Assistance Appeals Panel which is comprised of three administrative law judges. In cases where the case manager's decision has been sustained and the recipient has continued to receive services, the Recipient Appeals Section refers the case to the Division of Program Compliance. That division should notify the recipient of the effective date of the recipient's responsibility to pay for these continued services.

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## **CASE MANAGEMENT QUARTERLY RE-EVALUATION**

The case management provider is responsible for completing for every recipient, on a quarterly basis from the recipient's entry to AIDS/ARC waiver services, a quarterly re-evaluation. This re-evaluation must be documented by updating the Long-Term Care Assessment (DMAS-95) and the plan of care, if necessary, and noting in the recipient progress report for that month that the case management team met to re-evaluate the recipient's continued need for services. (See Appendix B for a sample of this form.) This documentation must include who the members of the case management team were and any changes to the plan of care which occurred as a result of this meeting. The case manager must, at a minimum, meet face-to-face with the individual receiving services and consult with the other service providers, the individual's physician, and other professionals involved in providing care to the individual in the completion of this re-evaluation.

The case manager will use the recipient progress report to summarize the quarterly re-evaluation: the recipient's social support, environment, special needs, and the providers' ability to render appropriate and adequate care. The provider will update the assessment (DMAS-95) by entering the updated information in the next available column on the most recent DMAS-95 in the recipient's file (the DMAS-95 has four columns available for updates). The following must be updated:

- Provider Name and Number on Page 1 under Summary of Providers;
- Dates of Assessment on Page 1 under Utilization Information;
- Joint Motion on Page 2 and any other information if different from that previously submitted;
- All of the information on Page 3; and
- Medications, if changed, and Medication Administration on Page 4.

Pages 5 and 6 should not be updated. An example of an updated DMAS-95 is in Appendix B. Instructions and definitions used to complete the required entries on the DMAS 95 can be found in the Long-Term Care Assessment Process manual.

The provider should file the documentation of the quarterly re-evaluation for review by DMAS staff during the on-site visit.